Assistwide Limited

St Martins Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection was carried out on 07January 2017 and was unannounced. St Martins is a three storey property in a residential area of Wallasey close to the town centre. The home is registered to accommodate up to 16 people requiring personal care. At the time of inspection 15 people were living at the home.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of inspection the service had a manager in post who was registered with Care Quality Commission since July 2011.

During our inspection, we found breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

These breaches related to the safety of the premises and the management of medicines. You can see what action we told the provider to take at the back of the full version of the report.

The service had systems in place to ensure that people were protected from the risk of harm or abuse. We saw there were policies and procedures in place to guide staff in relation to safeguarding adults and staff spoken with were knowledgeable with regards to safeguarding and whistleblowing.

During our visit we found that the water systems for legionella had not been tested and the service had not had an official fire risk assessment for a number of years. This meant we could not be certain the building was safe.

We checked the medication management arrangements at the home. We found that the balance of medication stock that we sampled did not match what had been administered. This indicated that medication had not been given correctly.

Risk assessments and care plans were in place for people living in the home, however the risk assessments documentation were not always used appropriately this meant if there were significant changes to a person's risk assessment then this information would not be readily available to inform staff practice.

We identified that the reviewing systems of care plans and risk assessments had not been carried out according to the homes own policies and quality assurance processes that had been put into such as audits were not always effective.

We found that people had access to sufficient quantities of nutritious food and drink throughout the day and were given suitable menu choices at each mealtime, these options had been chosen by the people who lived at St Martins Residential Home, however not all staff had knowledge of the dietary requirements of people living in the home. This meant that people could have been at risk of receiving inappropriate diets.

We found that the Mental Capacity Act 2005 and the Deprivation of Liberty (DoLS) 2009 legislation had been adhered to in the home. We checked whether people's legal consent to the care they were provided with, had been sought and we found that it had. The registered manager told us people at the home had capacity and were able to keep themselves safe outside of the home,. This meant that no one at the home required a deprivation of liberty safeguarding to keep them safe. The registered manager however was able to tell us of actions that could be taken regarding depriving someone of their liberty if this became necessary.

Staff were recruited safely and there were sufficient staff working at the home to support the people living there. Staff had received training and were supervised regularly. Part of this training was mental capacity act training and staff are able to tell us about the Mental Capacity Act and the deprivation of liberty safeguards.

People who lived at the home were able to tell us who the registered manager and their keyworker was and said they felt comfortable approaching any staff if they felt the need to complain. We saw that the registered manager was a visible presence in and about the home and it was obvious that they knew the people who lived in the home well.

Each person's bedrooms had been personalised by them people who lived in them and those who were able were able to lock their bedroom doors, choose who entered their rooms and go in and out of the front door freely.

The staff in the home knew the people they were supporting and the care they needed. We observed staff to be kind and respectful and the home supported the people to access health appointments and a range of activities. This promoted their independence and well-being. The people living in the home were able to express their views and were able to choose the way they spent their day. People's views and opinions on the service provided were regularly sought. For example there were monthly resident meetings and satisfaction surveys were people were able to give their feedback on the quality and safety of the service provided.

The complaints procedure was accessible to people living in the home and had been followed by the service. There was a full description of the procedure in the service user guide and a shortened version available.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments were not always reviewed appropriately.

The arrangements in place for the administration of 'as and when' required medication was not sufficient as there were stock imbalances.

The home did not have a current legionella's or fire risk assessment to protect people from potential harm.

Staff were recruited safely and there were sufficient staff working at the home to support the people living there.

Is the service effective?

Requires Improvement

The service was effective

People were given enough to eat and drink and a choice of suitable nutritious foods, however not all staff had knowledge of the dietary requirements of people living in the home.

Support staff had received an appropriate induction to do their job role effectively and all staff received appropriate supervision and appraisal.

The requirements of the Mental Capacity Act (2005) had been fully implemented to protect people's rights. Staff had an understanding of mental capacity and how this applied to people who lived at the home.

Is the service caring?

Good

The service was caring

Information relating to people living at the home was stored confidentially.

People we spoke with told us the staff were kind and treated them with respect. Our observations confirmed this.

A service user guide was available had been reviewed regularly and so held up to date information for people who lived at the home to refer to.

Is the service responsive?

Good

The service was responsive

The complaints procedure was accessible to people living in the home and had been followed by the service.

A range of social activities was provided.

People had prompt access to healthcare professionals when required.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Audits had been implemented and were completed monthly but had not identified the medication or risk assessment issues that we identified during the inspection.

The service had a manager who was in the process of registering with the Care Quality Commission. Staff said they felt supported by the manager

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St Martins Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 07 January 2017. The inspection was unannounced. The inspection was carried out by one adult social care (ASC) inspector. Prior to the inspection we asked for information from the local authority quality assurance team and other health professionals. We checked the website of Healthwatch Wirral for any additional information about the home to help us plan our visit. We reviewed the information we already held about the service and any feedback we had received.

During the inspection we spoke with six people who lived at the home, six staff including the cook, maintenance person, support staff and the registered manager. We looked at the communal areas that people shared in the home and a sample of individual bedrooms. We reviewed a range of documentation including four support records, medication records, four staff files, policies and procedures, health and safety audits and records relating to the quality checks undertaken by the manager.

We looked around the premises and spent time observing the care and support provided to people throughout the day.

Requires Improvement

Our findings

People who used the service said they felt safe when supported by the staff. They told us that staff were "Nice". One person told us that the staff "Oh yes I feel very safe".

We asked staff members if they knew how to safeguard people from the risk of abuse and asked if they felt confident to report any type of potential abuse. All the staff we spoke with were able to show an understanding of the different types of abuse and how to report abuse. We saw that policies and procedures were in place for safeguarding and that the home reported safeguarding incidents to the Local Authority and Care Quality Commission appropriately and in a timely manner. We also saw how residents meetings were used to ensure that all people living in the home were aware of what abuse was, this included bullying.

The home had access to a maintenance person who worked between St Martins Residential Home and a second service. We were told that resources were available when repairs were needed in the building. We were able to see evidence of weekly checks that included fire alarms, door alarms and emergency lighting. We looked at a variety of safety certificates that demonstrated that utilities and services had been tested and maintained such as gas and electric.

However, water systems for legionella had not been tested and the service had not had an official fire risk assessment for a number of years. This meant that we could not be certain that the building was safe. Legionella bacteria naturally occur in soil or water environments and can cause a pneumonia type infection. It can only survive at certain temperatures. Under the Health and Safety 1974, a provider has a legal responsibility to ensure that the risk of legionella is assessed and managed. By not having an up to date risk assessment, the provider could not be sure that the risks of people contracting a Legionella type infection were mitigated against.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that the premises were safe for use.

We inspected medication storage and administration procedures in the home. We found the medicine trolley was secure and clean and the treatment room was locked when not in use. We checked people's medication administration charts.

The majority of medication was administered via a monitored dosage system supplied directly from a pharmacy. There were some people who had boxed medications that were not dispensed in the monitored

dosage system for example 'as and when required' medications such as painkillers.

We saw that any medication that was prescribed to be used 'when required' medication had not been properly recorded on the person's records with the name of the medication, dosage and frequency detailed for staff to follow. We checked a sample of the stock of medication in the medication trolley and compared it to people's medication administration records. The balance of stock that was sampled did not match what had been administered. This indicated that medication had not been given correctly.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure the proper and safe management of medicines.

We looked at the risk assessments relating to the care of some of the people who lived at the home. We saw that people's risks assessments included risk of self-harm, falls and mobility. We saw that risks were clearly identified and monitored closely. For example, one person had a self-medication risk assessment and staff were monitoring this in accordance with the person's risk management plan. We saw that people's risk assessments were monitored and regularly updated to reflect people's needs and when their needs had changed. However, we also saw how staff were sometimes using the documents for the review of the risk assessments as daily communication log sheets. This meant that if there were any significant changes to a person's risk assessment then this information would not be readily available to inform staff practice.

Personal emergency evacuation plans (PEEPS) had been completed for all of the people who lived in the home and were readily available in case they were required. We saw that the information in people's PEEPS matched what information was held in people's care plans and risk assessments. This showed that the information provided in PEEPS was accurate and up to date.

We looked at the records for accidents and incidents, we saw that appropriate action had been taken following each event, for example referrals to the falls team. This meant people were monitored and health issues were identified and acted on in a timely manner. We saw that there were cleaning systems in place and that the home was clean and not malodourous.

We viewed four staff recruitment files and found that all the appropriate recruitment processes had been followed and that and checks had been made. All files contained two references, proof of identification and had appropriate criminal records checks on each person. This showed us that appropriate employment checks were carried out to ensure staff were safe and suitable to work with vulnerable people prior to employment. We also saw that there were sufficient staff on duty to meet the needs of the people living in the home, this was supported on speaking with staff and people living in the home.

Requires Improvement

Our findings

When we asked people whether staff had the appropriate skills or knowledge to deliver an effective service, the feedback was positive. We were told by one person "Yes [manager] has them well trained" and another person told us "Oh yes they know".

We looked at four staff files that showed that each staff member had either attended or successfully completed the provider's induction schedule and that staff had attended a variety of training courses that included first aid, fire safety, infection control and safeguarding. We also saw that 18 staff had attended and achieved their Health and Social Care Diplomas, either level 2 or 3. We did however note that some training was still required for some staff in mental health topics as the home offered a specific mental health residential service, this meant that was a risk that staff skills and knowledge was not appropriate to deliver a safe care.

We saw evidence that the registered manager had implemented a supervision and appraisal system for the staff. Supervision provides staff and their manager with a formal opportunity to discuss their performance, any concerns they have and to plan future training needs. Staff we spoke with confirmed that they received regular supervision. One staff member told us "Yes they're regular, and helpful, it's good to be able to say things in confidence".

People we spoke with were able to tell us where the menus were situated and the feedback we received about the food was positive. One person told us "The foods ok, we get a choice". We observed the cook supplying snacks throughout the day and we saw how people living at the home were able to make themselves hot drinks whenever they wanted. We noted that the home had a communal dining area and that people were able to choose where they wanted to sit to eat their meal. We visited the kitchen and other storage areas and found that sufficient supplies of food including fruit and vegetables were available.

We saw that each person had a nutritional care plan in place that was reviewed. On discussion with some staff they were unable to tell us about the dietary needs of people living in the home. This meant that there were insufficient systems in place at the home to ensure new catering staff were provided with information about people's dietary needs. This was brought to the manager's attention who informed us that this would be acted on immediately.

We saw that a residents meeting had been held for the cook to identify people's wishes for new menus. We saw that people's preferences and suggestions had been catered for, this included healthier options.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. It was clear that the manager had a full and detailed understanding of the MCA and its application and people had MCA assessments. We saw how staff had received mental capacity training and in discussion were able to show that they had an understanding of the principles.

We saw that the bedrooms of people who lived at the home were personalised for example one person had a bell on their door for visitors to press for attention. This indicated that peoples wishes regarding privacy was respected.

Good

Our findings

One of the people who lived at the home told us, "They're friendly here, they listen to you" another said "They're very caring". People told us that they made everyday decisions themselves, one person said, "If I want to do anything I will". We observed people moving freely around the home and leaving if they wanted, one person said "I can go out when I want".

We observed staff throughout the inspection supporting people who lived at the home. Interactions between staff and the people they cared for were positive. All the staff we observed were respectful of people's dignity and independence. It was clear that staff had warm, positive relationships with people and that the staff were trusted by the people who lived at the home. We were told by one person "I like it here". People agreed that they were supported to be as independent as possible. One person said, "You only have to ask".

When we spoke with the staff they showed an awareness of the needs of the people who lived in the home and were able to tell us of what care was needed and preferred. It was obvious from our discussions that the staff knew the people well and they spoke about them warmly. We saw staff addressing people in the manner they preferred and using communication strategies appropriate for individuals. One person told us how staff and manager would take them out for a meal as they really enjoyed it.

We observed that confidential information was kept secure either in the main office or the locked medication room. This demonstrated that the home adhered to their own confidentiality policy in order to protect people's privacy and dignity needs.

We reviewed the provider's service user guide. This included information about advocacy, monthly residents meetings, healthcare, medication and recreation. This document was reviewed regularly so gave up to date information to both people using the service and visitors.

We observed a residents meeting being held and this was attended by the majority of the people living in the home. When we asked people about this they told us that a resident meeting took place every few months and we saw evidence that confirmed this. Every person we spoke with felt they had a say in the running of the service. This demonstrated that people were given appropriate information in relation to their care and treatment.

Good

Our findings

People told us they were satisfied with the way care was provided, could not fault the approach of the staff, and they felt listened to. We were told "They support you if there's anything wrong". We asked if people felt comfortable raising concerns or complaints. One person told us "I'd go to [manager], she's good one of the best since I've been here", and another person said "I'd go to [manager]".

We looked at the complaints procedure and saw that it was clear and comprehensive. This was available in the 'St Martins Residential Home Service User Guide'. This had information about other professional bodies that people could contact in the event of a complaint if needed.

We reviewed four support files, and found all the important information about the person and their support needs was documented in the file. The care files contained plans describing how the person needed to be supported. Assessment and care planning information identified people's needs and the care they required. For example, there were assessments about finances, nutrition communication and sociability. We saw that signatures of the people they were about were recorded to say that they had been involved in the implementation of the support plan, this was supported through discussion with people living in the home.

We observed people during our visit and saw that each care plan was reflective of the person it was written about. We also saw how there was a keyworker system in place and on discussion with people living in the home it was obvious that they knew who their keyworker was. One person told us "Yes I know my keyworker, it's nice to have someone to go to". A keyworker's role includes understanding a person's particular needs and as key worker to can coordinate and organise the service to meet those special needs.

We saw that people had prompt access to medical and other healthcare support as and when needed. One health professional told us how the home had been very proactive when a person had become unwell and immediately contacted the appropriate mental health support. This indicated that the service responded appropriately to people's mental health, medical and physical health related needs.

We were able to see through documentation and through discussion with people living at the home that people were involved in the recruitment of new staff. One person living in the home was able to tell us how they had opinions that were listened to by the management. One staff member told us "All the residents knew my name before I started here".

The home didn't employ an activities co-ordinator so the staff offered a range of activities to meet people's

social needs. We also saw through the residents meeting that people were regularly asked for input and suggestions regarding their preferences about outings and activities. We were also able to see that if a person did not want to join in any of the activities then they were given the opportunity to refuse. We also saw how there was an activities corner that had a large amount of resources available for anyone who wanted to access this outside of structured times. We found that people living in the home were able to express their views and were able to choose the way they spent their day.

We asked people living at St Martins Residential Home if there were any restrictions regarding visitors. Everyone we spoke to said that there was no restriction. One person told us "Oh there's no problems with visitors coming".

Requires Improvement

Our findings

The service had a registered manager in post who had been registered with CQC since 2011. The manager was supported by a senior support worker and there were 23 other staff employed by the home.

By law services are required to notify the Care Quality Commission (CQC) of significant events. We saw that although some incidents had been appropriately reported to the Care Quality Commission not all notifiable occurrences had been. We discussed this with the manager who assured us that this would be addressed for the future.

The registered manager had a monthly meeting held with the provider of the service, however the registered manager had not received any other support such as formal supervision. This indicated that the registered manager had minimal support in their role and was unable to formally receive feedback or give suggestions regarding the effective running of the home.

The registered manager had implemented audits to ensure the quality of the service. These included accidents, finances and medication. However, we saw that there were errors regarding medications that indicated the medication audits had not been effective. We also saw that the manager did not formally audit the support plans of the people living in the home and we identified issues with reviews of the files that indicated the quality processes were also not effective. The provider had also not identified that fire and infection control procedures needed reviewing. This meant the quality of the service had not been fully monitored.

Staff we spoke with felt supported by the management team. One staff member said "[Manager] is really good", another staff member told us "I've had brilliant support [manager] is so nice". The manager was visible throughout the day and led by example. They knew all the people they interacted with by name and was able to give us an insight into the person's needs and requirements.

We saw that staff were being supported through training and supervision however we identified that specific mental health training was needed. Records confirmed that regular team meetings were held and showed staff were able to air views and make comments about the service.

The policies in place were current and regularly updated by the registered manager. These included health and safety, fire procedures, confidentiality, whistle blowing, medication, disciplinary procedures and recruitment. We saw quality questionnaires were in place this meant that people would see that their

opinions mattered and were acted on and showed a wish to work with people to improve the service. Records confirmed that people who had provided feedback had been listened to and as a result some changes had been made to the way the service was provided. An example of this was regarding the menus and healthier choices.

All the people we spoke to who lived at St Martins Residential Home knew who the manager was and said they would have no hesitation approaching them or any of the staff if they were worried about anything. This showed the home had an open and inclusive culture.

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure the premises were safe to use and medicines were not safely managed.